Impact of LTCIP Strategies on Persons with Developmental Disabilities:

The three strategies described below will work alone and together to position San Diego to gain experience with providing resources to and managing the care of individuals who currently are not served systematically or served well on a population basis.

1. **Network of Care**- The County of San Diego has purchased a software product created with grant funds from the California Department of Aging called the "Network of Care". It was designed and developed in Alameda County as a web-based approach to user-friendly information gathering on long term care services for consumers and caregivers. It has the potential and capability of becoming a useful single point of entry source for the LTCIP target population.

The LTCIP strategy for the Network of Care is to procure resources to formulate and perform βeta testing with consumers and caregivers in San Diego. Additionally, this testing would be expanded to several groups: information and referral specialist who are County Call Center staff as well as information and referral staff in the broader community; and health and social service providers. The goal is to develop a continuous quality improvement program that will allow all stakeholders in San Diego access to a set of resources that is consistently accurate and meets the needs of all users.

Impact on Developmental Disabilities population: SDRC staff and/or SDRC clients and caregivers could be potential participants for the βeta testing. This would provide targeted feedback about how the Network of Care could be enhanced to better serve the developmental disabilities population. Other ideas?

2. **Socio-Medical Care Management** (Managed Fee-for-Service)- the strategy for Socio-Medical Care Management is to develop an improved system of care that meets the needs of persons with chronic conditions. The major goals of Managed Fee for Service (MFFS) are similar to those of a fully-capitated, integrated program: to streamline access for consumers to primary, acute and long term care services, to improve quality, and to provide care in the most cost-effective manner possible. MFFS activities often include prior authorization, concurrent review, provider selection, provider and consumer education, coordination between Medicare and Medicaid benefits, and demand management.

The LTCIP strategy for developing a Socio-Medical Care Management system in San Diego involves identifying, engaging and providing incentives to local physicians/groups who serve elderly and disabled persons with chronic disease and providing them with care management team resources to improve patient outcomes in the community. "After office" services will become part of the physician treatment plan as the care manager links the physician and his/her staff to community-based care and communication across the health and social service continuum. Office staff would also be trained on use of the Network of Care as a resource for staff and patients.

Impact on Developmental Disabilities population: the enhanced care coordination and case management services would provide persons with developmental disabilities with more streamlined access to medical, social and supportive services. Clients would also be encouraged to actively participate in the care planning process. Are stakeholders interested in including persons with developmental disabilities in this pilot?

3**. Health Plans/Pilots** – In order to test more fully-integrated models and their effectiveness in managing care and improving outcomes for persons with chronic disease, two voluntary pilots will be developed and implemented in conjunction with the State Office of Long Term Care. The Healthy San Diego Health Plans Pilot will develop a plan centered around the current Medi-Cal managed care program expanding expertise and service array to implement the integrated delivery of health, social, and supportive services for a capitated rate from the state. One goal will be to demonstrate the capacity of the existing Medi-Cal

managed care environment to provide a continuum of care to frail elderly and disabled persons who are dually eligible.

The second health plan pilot will be one proposed by Lifemark Evercare, a national leader in integration. Lifemark Evercare proposes to contract with the state Office of Long Term Care for a capitated rate to provide an integrated continuum of health and social services for individuals on Medi-Cal who are at a skilled nursing facility level of care living in a community setting. In-Home Supportive Services, and its funding, is proposed to be included. Inclusion of this target population will be on a voluntary basis.

The goals of both pilots are:

1. To improve the quality of care and outcomes through management of health and social services for dually eligible Medicare and Medi-Cal recipients from a single entity;
2. To maintain individuals in the least restrictive setting including home and community settings;
3. To comply with the provisions set forth in the Olmstead Decision; and
4. To move incentives and resources to community-based care as a deterrent and replacement for higher-level acuity care, including repeated emergency room and hospital use.

Impact on Developmental Disabilities population: Persons with developmental disabilities that are members of a HSD health plan would benefit from the improved coordination and integration of health and social services Other thoughts? How do stakeholders feel about possibly including persons with developmental disabilities in these pilots?